

Case Number:	CM14-0163681		
Date Assigned:	10/08/2014	Date of Injury:	08/02/2006
Decision Date:	11/12/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/06/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 61-year-old woman who sustained a work related injury on August 2, 2006. Subsequently, she developed chronic low back pain. The patient underwent posterior stabilization fusion and TLIF at L4-5 and L5-S1 on July 12, 2012. A CT of the lumbar spine performed on August 21, 2013 showed facet arthropathy with postoperative change L4-5 and L5-S1 and with retrolisthesis L1-2, L3-4, and L5-S1; neural foraminal narrowing includes L1-2 mild left, L3-4 mild to moderate right, and L5-S1 moderate right neural foraminal narrowing. Prior treatments have included medications (Norco, Flexeril, Prilosec, Elavil), acupuncture (helped with her pain level), chiropractic treatments (completed 25 sessions), and heat and ice with other topical remedies. According to the progress report dated August 8, 2014, the patient complained of aching low back pain, that she rated at 5/10, with radiation to tailbone into bilateral buttocks described as intermittent sharp spasms. Patient denied any numbness, weakness or tingling in bilateral lower extremities. She last worked in July of 2011. The patient noted some memory issues since taking Elavil and reported associated stomach pains when not taking Prilosec. Her physical examination revealed diffuse tenderness to palpation of the lumbar spine. Her gait was normal and non-antalgic. The range of motion of the lumbar spine was reduced (flexion 25 degrees, extension 0-5 degrees, left and right lateral bending 15 degrees). She has decreased sensation right L3 and L5 dermatomes, bilateral psoas, right quads, right hamstring, and EHL are +4/5. Positive straight leg raise on the left and at 40 degrees with radiation to the mid-calf. The patient is tender to palpation about the left knee. The patient was diagnosed with lumbar radiculopathy. The provider requested authorization to use Right L3 and L4 TFESI, Hydrocodone/APAP, Cyclobenzaprine, Flexeril, and Orthopedic Follow-Ups.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Right L3 and L4 TFESI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit; however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, there is no clinical and objective documentation of radiculopathy. MTUS guidelines do not recommend epidural injections for back pain without radiculopathy (309). Therefore, Right L3 and L4 TFESI is not medically necessary.

Hydrocodone/APAP 7.5 MG, Take One 3 Times A Day #120 Dispensed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 179.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no documentation of functional and pain improvement with previous use of Hydrocodone. There is no documentation of

continuous compliance of patient to his medications. Therefore, the prescription of Hydrocodone/APAP 7.5 mg #120 is not medically necessary.

Cyclobenzaprine 7.5 MG, Take One 2-3 Times A Day #30 Dispensed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to MTUS guidelines, Cyclobenzaprine a non-sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The guidelines do not recommend being used for more than 2-3 weeks. The patient in this case does not have clear significant functional improvement with prior use of muscle relaxants. There is no indication of recent evidence of spasm. Cyclobenzaprine was previously used without clear documentation of efficacy. Therefore, the request for Cyclobenzaprine Hydrochloride Tablets 7.5 Mg Qty: 30 is not medically necessary.

Flexeril 10 MG #30 Dispensed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to MTUS guidelines, Flexeril, a non-sedating muscle relaxant, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. There is no recent documentation of pain and spasticity improvement. Therefore the request for authorization Flexeril 10 MG, # 30 is not medically necessary.

Orthopedic Follow-Ups to Evaluate The Patients Left Knee and Right Lower Extremity Complaints: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter: Office Visits

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, early intervention Page(s): 32-33.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for an orthopedic evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. The provider did not give a justification for the follow up visit. There is no documentation of the reasons, the specific goals and end point for this consultation. Therefore, the request for Orthopedic Follow-Ups to Evaluate the Patients Left Knee and Right Lower Extremity Complaints is not medically necessary.